RFP-4-79
Attachment N
Provider Claims Dispute Resolution

[NOTE: The office of Medicaid Policy and Planning (OMPP) has begun the process to promulgate a provider claims dispute resolution process into a managed care rule. The Notice of Intent is due to be published in the June 2004 Indiana Register. Until the rule is finalized, the MCO must follow a process as outlined below.]

1.0 Provider Claims Dispute Procedure Overview

The MCO must establish a written claims dispute resolution procedure that is applicable to both in-network and out-of-network providers. The MCO must distribute its claims dispute resolution procedure to all in-network providers and publish it on its website for all providers to access. The MCO must make its claims dispute resolution procedure available to out-of-network providers in hard copy upon the provider's request.

The MCO may negotiate the terms of a written claims dispute resolution procedure with in-network providers; but if the MCO and an in-network provider are unable to reach agreement on the terms of such procedure, the out-of-network provider claims dispute resolution procedure approved by OMPP will govern the resolution of such in-network provider's claims with the MCO.

The MCO must submit its written claims dispute resolution procedure for out-of-network providers (and in-network providers in the absence of an agreement) to OMPP for approval as part of the Readiness Review for this contract. The MCO's claims dispute resolution process must include, at a minimum, the following elements:

- A statement noting that providers objecting to determinations involving their claims will be provided procedural due process through the MCO's claim resolution procedure.

- A description of both the informal and formal claim resolution procedures that will be available to resolve a provider's objection to a determination involving the provider's claim.

The MCO's claim resolution procedures for out-of-network providers (and in-network providers in the absence of an agreement) may not include elements that restrict or diminish the claim review procedures, time periods or subject matter as described below.

The MCO must maintain a log of all informally and formally filed provider objections to the MCO's claims determinations. The logged information must include the provider's name, date of objection, nature of the objection and disposition of the dispute. The MCO must submit quarterly reports to OMPP regarding the number and type of provider objections as described in the MCO Reporting Manual.

Through the MCO's claims dispute resolution procedure (i.e., informal, formal and arbitration procedures), a claim that is finally determined to:

- Have sufficient supporting documentation must be processed by the MCO within 30 calendar days after the final determination is made.

- Lack sufficient supporting documentation must be processed by the MCO within 30 calendar days after the provider submits the requisite supporting documentation to the MCO.

The MCO must allow the provider 30 calendar days to submit sufficient supporting documentation after issuing a written notice to the provider that the claim lacked sufficient supporting documentation.

2.0 Informal Claims Dispute Resolution Procedure

The MCO must have an informal claim resolution procedure that allows the provider and the MCO to make verbal inquiries and to otherwise informally undertake steps to resolve the provider's disputed claims issues. The informal claims resolution procedure must be available for the resolution of claims submitted to the MCO by the provider within an allowable claims submission timeframe as defined under Federal and State law.

The procedure must precede a formal claim resolution procedure and must attempt to resolve a provider's objection to the MCO's determination of the provider's claim, including a provider's objection to:

- Any MCO determination regarding payment for the provider's claim, including the amount of such payment; and

- The MCO's determination that a provider's submitted claim lacks sufficient supporting information, records, or other materials.

The MCO must allow the provider to initiate the procedure to determine the payment due for a claim in the event the MCO fails to notify the provider within 30 calendar days after the provider submits the claim, of either the MCO's determination:

- Regarding payment for the provider's claim; or,

- That the provider's claim lacked sufficient supporting information, records, or other materials.

The provider can initiate the informal claims dispute procedure by submitting a written notice to the MCO within 60 calendar days of the provider's:

- Receipt of the MCO's written notification of its determination regarding the provider's claim; or,

- Submission of a claim without receiving the MCO's written notification of its determination regarding the provider's claim.

The provider's written notice must indicate the reason for his/her objection (i.e., having received a determination or having not received a determination from the MCO) and explain his/her objection.

3.0 Formal Claims Dispute Resolution Procedure

In the event the matter submitted for informal resolution is not resolved to the provider's satisfaction within 30 calendar days after the provider commenced the informal claim resolution procedure, the MCO's claims dispute resolution procedure must allow the provider 60 calendar days from that point to submit to the MCO written notification of the provider's

election to submit the matter to the formal claim resolution procedure. The provider's notice must specify the basis of the provider's dispute with the MCO. The MCO's receipt of the provider's written notice must initiate the formal claim resolution procedure.

3.1 Formal Claims Dispute Resolution Panel

The MCO's formal claims dispute resolution procedure must include a panel of one or more individuals selected by the MCO to conduct the formal claims resolution procedure.

3.1.1 Panel Members

Each panel member must be knowledgeable about the policy, legal, and clinical issues involved in the matter that is the subject of the formal claim resolution procedure. An individual who has been involved in any previous consideration of the matter by the MCO may not serve on the panel. The MCO's medical director, or another licensed physician designated by the medical director, may serve as a consultant to the panel in the event the matter involves a question of medical necessity or medical appropriateness.

3.1.2 Panel Responsibilities

The responsibilities of the panel include the following:

- Considering all information and material submitted to it by the provider that bears directly upon an issue involved in the matter that is the subject of the formal claim resolution procedure.

- Allowing the provider an opportunity to appear in person before the panel, or to communicate with the panel through appropriate other means if the provider is unable to appear in person, and question the panel in regard to issues involved in the matter. The MCO must not require that the provider have an attorney present for the purposes of the formal claim dispute review procedure.

- Determining an outcome based on the information and materials submitted by the provider and MCO; and,

- Providing written communication the panel's determination to the provider within 45 calendar days after the commencement of the formal claims dispute resolution procedure.

3.1.3 Panel Determination Process

Within 45 calendar days after the commencement of the formal claim resolution procedure, the panel must deliver to the provider the panel's written determination of the matter upon which it has deliberated. Such determination shall be the MCO's final position in regard to the matter. The written determination must include, as applicable, a detailed explanation of the factual, legal, policy and clinical basis of the panel's determination.

In the event the panel fails to deliver to the provider the panel's written determination within 45 calendar days after the commencement of the formal claim resolution procedure, the MCO can consider provider's claim denied by the panel.

The panel's written determination must include notice to the provider of the provider's right to submit to binding arbitration the matter that was the subject of the formal claim resolution procedure within 60 calendar days of the provider's receiving of the panel's written determination. The MCO must allow the provider the right to submit the matter to binding arbitration if the panel has failed to deliver its written determination to the provider within the required 45 calendar day period.

4.0 Binding Arbitration

The MCO must conduct any procedure involving binding arbitration in accordance with the rules and regulations of the American Health Lawyers Association (AHLA), pursuant to the Uniform Arbitration Act as adopted in the State of Indiana at IC 34-57-2, unless the provider and MCO mutually agree to some other binding resolution procedure. However, OMPP requires that any MCO and provider subject to statutorily imposed arbitration procedures for the resolution of these claims disputes must follow the statutorily imposed arbitration procedures, to the extent those procedures differ from, or are irreconcilable with, the rules and regulations of the American Health Lawyers Association (AHLA), pursuant to the Uniform Arbitration Act as adopted in the State of Indiana at IC 34-57-2. OMPP requires that the fees and expenses of arbitration must be borne by the non-prevailing party.

The provider and MCO may agree, within the required 60-calendar day period, to include in a single arbitration proceeding multiple formal claim resolution procedures involving the MCO and the provider. If the provider and MCO are not able to agree, the selected arbitrator has the discretion to include in a single arbitration proceeding multiple formal claim resolution procedures involving the MCO and the provider.